Vermont Dual Eligible Demonstration

Stakeholder Questions with State Responses

August 5, 2013

Note: This document includes the Stakeholder Questions and State Responses Document distributed at the June 25, 2013 Stakeholder Meeting as well as State responses to Stakeholder questions submitted after that. To distinguish between the two, the latter questions and responses are indicated by [8/5/13] *before the text of the question.*

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Overall Demonstration Parameters

1. **[8/5/13] In Vermont's DE Demonstration documents, is there a difference between the use of the terms "the State" and "DVHA"?**

   Yes. The term "the State" is referring to the State of Vermont, which will be entering into the DE Demonstration MOU with CMS. "DVHA" refers to the Medicare-Medicaid Plan with which the State will contract to serve the dual eligible enrollees.

2. **[8/5/13] The Dual Eligible Demonstration must align with the other health care and payment reform initiatives that are already moving forward in Vermont. The processes of providing the dual eligible population enhanced levels of care coordination should not require the construction of a separate administrative structure by providers or administrators. If the demonstration creates inconsistencies in administration, benchmarking, and quality measures across different Vermont initiatives, it would reduce potential savings that are expected as a result of this and other reform projects. We agree with the Administration's intention to align with ongoing health reform efforts and would be interested to understand the planned steps toward this stated goal.**

   The State agrees that the DE Demonstration must align with the other health care and payment reform initiatives that are already moving forward in Vermont. The State is developing a new integrated governance structure to assure alignment between the work being undertaken by the SIM grant and the DE Demonstration. This integrated SIM/Duals governance structure is designed to be a robust public/private partnership by including state staff, health care payers, health care and LTSS providers, advocates, and other stakeholders at multiple levels. The goal of integrating the governance and management processes of the Dual Eligible Demonstration and the SIM Grant is to ensure alignment across administration, benchmarking standards, quality/performance measures, and payment reform efforts.

   In addition, two of the primary reasons for delaying implementation of the ICP-Plus approach is to allow time for the payment reform work of Vermont's State Innovation Models (SIM) grant to be developed so that the ICP-Plus bundled service payment methodology can be aligned with the broader health care reform payment methodologies being developed under the SIM grant, and to allow the Medicaid ACO model to be fully developed and implemented so that the more complex ICP-Plus model can be implemented within the Medicaid ACO/Shared Savings Program context.

3. **Will the Dual Eligible (DE) Demonstration "go live" all at once or be phased in for some enrollees?**

   The preferred plan is to "go live" for the Dual eligible program all at once on January 1, 2015 and to not phase in the program. In other words, the State intends to have all Demonstration parameters in place by this date, including operational processes. This would also be the effective date of enrollment for all eligible DE individuals who choose not to opt out of the Demonstration prior to this date.

4. **[8/5/13] The implementation issues are significant. How will rules, regulations, procedures, etc., that now govern the service system, be retooled? The experience of the IFS initiative might be instructive. The plan to go live "all at once" will be a challenge and may not be realistic.**

It is not expected that existing rules, regulations, procedures that now govern the service systems utilized by dual eligible individuals will need to be altered for Year 1 of the Demonstration; rather the focus will be on implementing Enhanced Care Coordination (ECC) and performance measurement through a new funding stream and contracting mechanism between DVHA and Integrated Care Partnerships (ICPs). This makes the plan to "go live" all at once realistic. One of the reasons that the State has delayed implementation of the more complex ICP-Plus model until Year 2 of the Demonstration is to provide more time to understand and plan for the implications of bundling payments and expectations that cross rules, regulations and procedures of multiple departments.

5. [8/5/13] How will the State of Vermont demonstrate that it meets the CMS requirements of "Model of Care Elements"?

As part of DVHA's submission to be a Medicare-Medicaid Plan for the DE Demonstration, DVHA submitted a 239 page Model of Care (MOC) document to CMS in February 2013.The MOC component was reviewed by the National Council on Quality Assurance (NCQA) on CMS' behalf. DVHA received 153 out of 160 points (96%) which placed DVHA's MOC in the 85% to 100% category with a 3-year approval from NCQA (the maximum period granted).

6. [8/5/13] Will the status quo of non-dual enrollees in the CRT, DS and CFC waivers remain the same?

The DE Demonstration, and its policies and procedures, are targeted only to individuals dually eligible for Medicare and Medicaid.

Integrated Care Partnerships (ICPs) and Accountable Agents

7. What is an Integrated Care Partnership (ICP)?

An ICP is an affiliation of member organizations in a defined geographic region that is responsible for the provision of ***Enhanced Care Coordination (ECC) for dual eligible enrollees across all of their needs. In other words, ICPs provide ECC.*** *ECC Coordinators employed by the ICP member organizations will be responsible for working with the individual to conduct/coordinate a person-directed individual assessment, develop a care plan, and be their single point of contact across all their primary, acute, mental health, substance abuse, developmental, and long term care supports and service needs.*

8. What is an ICP Accountable Agent?

An ICP Accountable Agent is a member of the Integrated Care Partnership. The Accountable Agent is designated by the member organizations to contract with DVHA on behalf of all ICP members. The ICP Accountable Agent will be:

- *The recipient of DVHA payments for the provision of ECC in the ICP geographic area*
- *The entity that pays the ICP member organizations for the provision of ECC*
- *The contractual entity responsible for assuring the provision of ECC*
- *The conduit for data exchanges and other communications between the State, DVHA and ICP regarding the DE Demonstration, and*
- *The contractual entity accountable for ICP performance*

9. What are the differences between Integrated Care Partnerships (ICPs) and ICPs-Plus?

ICPs will receive payment from DVHA (through the ICP Accountable Agent) for providing enhanced care coordination. Integrated Care Partnerships-Plus (ICPs-Plus) will receive a capitation payment for a bundled array of services, in addition to providing enhanced care coordination. DVHA intends to issue a RFP to identify organizations that are interested in becoming an ICP beginning on January 1, 2015. The State and DVHA intend to delay such a RFP for ICPs-Plus until Year Two of the Demonstration.

10. [8/5/13] Is it a pre-requisite that an ICP-Plus must have been an ICP?

Yes. It is the State's intention that functioning as an ICP will build the necessary infrastructure to be able to perform successfully as an ICP-Plus.

11. Would the State consider an ICP-Plus pilot in Year 1?

No. The State and DVHA will not have the financial policies and procedures in place during Year 1 to support the ICP-Plus model.

12. [8/5/13] Could implementation of the ICP-Plus be delayed until Year 3? This would allow for more time to have the ICP care coordination process to properly work, improve information on service utilization and improve risk management/liability. Another option would to start shared savings the 2nd year and phase in down side risk year 3.

The State is willing to consider these suggestions.

13. What organizations are eligible to be in an ICP?

At a minimum, the ICP(s) must include a sufficient quantity and variety of member organizations to create an integrated person-directed system of ECC, including statutorily and state designated organizations that provide specialty case management / care coordination for enrollees in Population 1. Innovation and creativity is encouraged. Existing Vermont statutory and regulatory provisions will remain in effect (e.g. Certificate of Need, Designation).

14. [8/5/13] How will it work if a Designated Agency does not want to participate in an ICP?

It is the State's intention that all Designated Agencies (DAs), Specialized Service Agencies(SSAs), Home Health Agencies (HHAs) and Area Agencies on Aging(AAA) participate in the ICP in their geographic region, as the model is based on full participation of these organizations that have exclusive statutory responsibility to serve individuals with particular needs.

For dual eligible enrollees in the CFC, CRT, DS and TBI programs, these organizations already know the individuals and their needs. In addition, if an organization serving these enrollees does not participate in the ICP, the ICP would need to provide ECC for dual eligible enrollees who otherwise would have chosen the organization as their ECC provider. This would bi-furcate the Enrollee's care, as one organization would continue to provide their services (including case management) while another organization would provide the ECC. ICP participation by these organizations also will benefit enrollees not served in these specialized programs, as these organizations have unique insights and understanding of particular conditions that would be valuable for understanding the unique needs and coordinating individuals' care across the spectrum of primary, acute, mental health, substance abuse, developmental, and long term care supports and services.

In addition, there are benefits to organizations for participating in the ICP and the DE Demonstration, including but not limited to: infrastructure support to develop more robust data management; workforce training on the provision of comprehensive care coordination; additional funding for providing enhanced care coordination; potential for receiving performance incentives payments; groundwork for participation in other Vermont health care reform activities; etc.

15. [8/5/13] Can the ICP contract for ECC services with other providers or does the ECC have to be part of the ICP (in other words, does the provider of ECC services need to be "part" of the ICP; could home health contract a SASH coordinator to be an ECC)?

All entities that provide Enhanced Care Coordination must be a member of the Integrated Care Partnership (ICP). The ICP can determine the type of formal relationship that will exist between members, as long as this relationship allows funds to be transferred from the Accountable Agent to other ICP member organizations and enables accountability for performance.

16. [8/5/13] The ICP(s) should have flexibility in regards to the number of member organizations that will have staff providing ECC.

The purpose of an Integrated Care Partnership is to provide Enhanced Care Coordination (ECC); as such, other than the Accountable Agent, all ICP member organizations must have a role in providing ECC.

17. [8/5/13] If every member organization is required to provide ECC, there may not be enough beneficiaries choosing an individual organization to justify the infrastructure necessary to support the training and availability of that organization's ECC. It seems as though the staff providing ECC will need to be full time in order to assure availability as the one point of contact for the beneficiary and this may not be always be possible if every member organization must provide ECC since some organizations may not be chosen by very many beneficiaries.

The State recognizes that some Integrated Care Partnership member organizations may only need a few staff to provide ECC for the DE beneficiaries who have chosen them, and that the training, supervision and other supports for these staff will require additional infrastructure. That is one of the many reasons that the State has moved to contracting with a Partnership, rather than individual contracts with each ECC provider. The Integrated Care Partnership (ICP) can decide how to best support the provision of ECC across the range of ICP member organizations, and will be asked to provide their staff support approach in the ICP Request for Proposals issued by the State. DVHA also will provide Model of Care training for all ECC staff (a CMS requirement for Medicare-Medicaid Plans such as DVHA).

18. [8/5/13] Existing case managers may not be willing and able to assume the ECC responsibilities.

It would be in the best interest of dual eligible enrollees in the CFC, CRT, DS and TBI programs if their existing care coordinator/case managers assume the additional responsibilities of an ECC Coordinator since this is the person that knows the enrollee best. However, in the rare circumstance where the enrollee's ICP member organization believes that the existing case manager cannot assume the additional responsibilities of an ECC Coordinator, the ICP member organization may use the ECC funds to hire additional FTEs to perform the ECC functions. However, the ECC Coordinator must be the single point of contact for the enrollee, and perform all the duties required of ECC Coordinators. In addition,

the case manager must be an active member of the care team, and there cannot be duplication of services between the case manager and ECC Coordinator.

19. [8/5/13] Can an ICP form a separate organization within the Partnership to provide <u>all</u> the ECC for enrollees in their designated region?

The State might consider this option, with the following caveats (at a minimum):

- *Enrollees must have a choice of ECC providing organizations within the ICP*
- *The ICP must demonstrate in its proposal:*
  - *How the new entity is an aggregation of all other ICP member organizations , and not totally separate in terms of governance and oversight*
  - *The new entity has experience understanding the range of dual eligible enrollees' needs (e.g., mental health, developmental disabilities, physical disabilities, in-home supports, etc.)*
  - *How forming a new organization to provide ECC would be more efficient (from a cost and service quality perspective) than using existing member organizations to provide the ECC*
  - *The positive impact of forming a new organization on enrollees*

20. [8/5/13] Can the Integrated Care Partnership be any type of legal entity, i.e. a non-profit corporation, a limited liability company, etc.?

The Integrated Care Partnership can be any type of legal entity as long as the legal relationship permits funds to be exchanged between the Accountable Agent and other ICP member organizations and enables accountability for performance.

21. [8/5/13] Is a "Member" organization an actual legal member or an organization that has signed a Participation Agreement or Contract with the Integrated Care Partnership?

The Integrated Care Partnership (ICP) can determine the type of formal relationship that will exist between members, as long as this relationship allows funds to be transferred from the Accountable Agent to other ICP member organizations and enables accountability for performance.

22. [8/5/13] Can the ICP Accountable Agent be the Integrated Care Partnership entity? Thus, the Integrated Care Partnership entity could perform the Accountable Agent services itself or contract with another entity to perform them.

The Integrated Care Partnership "entity" is, by definition, the member organizations that have joined together to assure the provision of Enhanced Care Coordination (ECC) for dual eligible enrollees in their defined geographic region. This Integrated Care Partnership (ICP) can select one of its ECC-providing members to act as the ICP's Accountable Agent, or can include an organization whose primary role in the ICP is to provide the Accountable Agent functions and does not provide ECC. Even if the ICP Accountable Agent does not provide ECC directly, it is a member of the ICP.

23. [8/5/13] We recommend that the Accountable Agent not be a provider, and therefore a competitor to the organizations that are funded through it. We support maintaining service options.

The Integrated Care Partnership can choose to include an entity that does not provide ECC as the Partnership's Accountable Agent. However, some Partnerships may prefer to use a member organization that provides ECC as its Accountable Agent. The fact that enrollees

choose their ECC provider should help mitigated against any conflict of interest in this situation.

24. [8/5/13] If the Accountable Agent is a separate entity from the Integrated Care Partnership, can it be any type of legal entity?

The ICP Accountable Agent must be a member organization of the Integrated Care Partnership; it cannot be a separate entity. To perform its functions, the Accountable Agent must have a legal relationship with all member organizations within the ICP.

25. How will the regions for ICPs be defined by the State? How many ICPs can be in a region? Will existing service delivery regions for Designated Agencies, Home Health Agencies, Area Agencies on Aging and the Blueprint change?

For purposes of the DE demonstration, "region" is defined as a clearly identified geographic area with enough enrollees to make the ICP financially and administratively viable and efficient. The ICP response (submitted by the ICP Accountable Agent) to the DVHA RFP must specify the geographic area proposed to be served. DVHA reserves the right to negotiate the geographic areas proposed by ICPs in order to ensure that all enrollees have an ICP option.

There can only be one ICP in a region. However, depending on RFP response and State/DVHA selection, there could be multi-regional ICPs or one statewide ICP.

The regional designations for existing service delivery by Designated Agencies, Home Health Agencies, Area Agencies on Aging and the Blueprint program will not change.

26. What is the required relationship with ICPs in other regions?

There is no required relationship with other ICPs for Enhanced Care Coordination, since each ICP will have ECC responsibility for the enrollees in their region. However, this does not alter any relationships between organizations required in other contracts with the State (e.g., between designated agencies or CFC providers).

27. What is the required relationship between the ICP and acute care, medical and other health care providers?

There is no requirement regarding the relationship between the ICP and providers that are not ICP member organizations. However, the ECC Coordinators employed by the ICP member organizations must have relationships with all providers who are serving the ICP-enrolled individuals. This is the definition of enhanced care coordination.

Populations Served by ICPs

28. Who is eligible to receive Enhanced Care Coordination (ECC) from ICPs?

Vermont will assure that every DE Demonstration enrollee has choice of and access to a single point of contact that also provides person-centered, integrated care coordination and a comprehensive care plan. If the DE enrollee only has primary or acute health care needs and is not identified by DVHA as having high or moderate costs/risk factors, these functions will be provided by the enrollee's Primary Care Provider (PCP). Enhanced Care Coordination will be available through Integrated Care Partnerships (ICPs) for all other DE Demonstration enrollees that have needs beyond those managed by their PCP.

29. What populations does an ICP have to serve (i.e., CfC, CRT, DS, TBI, other high-use/at risk enrollees, other enrollees)?

ICPs must agree to provide Enhanced Care Coordination (ECC) for any DE demonstration enrollees in their geographic region that need ECC.

30. How will beneficiaries be assigned to an ICP? Would people be auto enrolled into ICPs?

The locus of a beneficiary's single point of contact/care coordinator will either be their primary care provider or an ECC Coordinator employed by an ICP, depending on the level of beneficiary's needs. Prior to enrollment in the Demonstration, all individuals will select both a primary care provider and an ICP member organization from which to receive ECC. As such, even those individuals with only primary and acute health needs will have an identified ECC Coordinator which they can access if they develop more complex needs. Care coordination triage protocols will be developed between the primary care practices, Blueprint Community Health Teams (CHTs), and ICP ECC Coordinators to ensure a seamless system from the perspective of the individual.

For those individuals who have not chosen an ICP member organization during enrollment in the DE Demonstration, the State will work with the relevant ICP Accountable Agent to assign an appropriate ICP member organization for the enrollee.

At a future date, if enrollees want to change their ECC provider, they can inform the ICP Accountable Agent who will assist them to select and enroll with a new ICP member organization. The enrollee's choice must always be honored. Once a new ECC provider is chosen, the ICP Accountable Agent must inform DVHA.

In addition to the above, local ADRC/SHIP programs will be available to assist enrollees with the selection of an ICP member organization during the initial enrollment process and at any point during the Demonstration if an enrollee desires a change. Enrollees may also seek further assistance from DVHA if desired.

31. 8/5/13 **Beneficiaries should not be asked to choose an ECC until they actually need and agree to accept this service. There is no basis for making the choice if the service is not needed and the beneficiary might choose a different ECC once they do need the service. If beneficiaries were to choose ECCs when they don't need them, the ICPs would at least have an obligation to maintain a roster of who has chosen which ECC and maintain those ECCs in some state of readiness. There is also the possibility that the beneficiary may contact their assigned ECC with questions or concerns despite the beneficiary not wanting or needing enhanced care coordination. There is no payment available in the care model to cover the expense of these possibilities. Having beneficiaries choose an ECC when they are not actually receiving ECC services would create confusion for beneficiaries and the ICPs alike.**

The State proposed that all beneficiaries choose their ECC provider upon their enrollment in the DE Demonstration for several reasons. First, this would facilitate timely access to ECC when it is needed (e.g., when an emergency situation occurs and the beneficiary who has not needed ECC could benefit from it immediately). In addition, educational materials will be distributed to all dual eligible individuals prior to the initiation of the DE Demonstration to explain the Demonstration; this information will include a description of the benefits of the Demonstration (e.g., ECC), the process for selecting the enrollee's Primary Care Physician and ECC member provider, and a detailed description of the criteria for receiving ECC services. It would be very difficult to prepare and accurately distribute two sets of materials –

one for enrollees that the State believes would benefit from ECC and one for those not in this category. In addition, such a bi-furcated process might be extremely confusing for the State and ICPs (e.g., keeping track of who received which mailing, and which enrollees must choose an ECC upon Demonstration enrollment versus those that must choose an ECC provider when ECC is newly needed), and could seem prejudicial to enrollees (e.g., believing that they are getting different benefits from the DE Demonstration).

The State acknowledges that the ICPs will need to maintain a roster of who has chosen which ECC and be ready to provide ECC when needed, and that a beneficiary may contact their assigned ECC with questions or concerns despite the beneficiary not wanting or needing ECC. To mitigate this administrative impact across multiple entities, an Integrated Care Partnership could choose to use their Accountable Agent to perform these functions on behalf of all Partnership member organizations.

32. What is the methodology for identifying complex cases to determine eligibility for Enhanced Care Coordination through an ICP?

DE Demonstration enrollees in the Choices for Care (CfC), Community Rehabilitation and Treatment (CRT), Developmental Service (DS), and Traumatic Brain Injury (TBI) programs will receive enhanced care coordination since enrollment in these programs is based on combinations of diagnoses and clinical or functional acuity.

For the remaining DE Demonstration enrollees, DVHA will either have internal capacity or contract with a vendor to perform data analytics to identify those in need of Enhanced Care Coordination. These analytics will use evidence-based algorithms to identify enrollees with high or moderate costs/risk factors and those with needs spanning across multiple service domains. DVHA will then notify the ICP Accountable Agent of DE Demonstration enrollees for whom they should offer Enhanced Care Coordination, and provide information about the acuity level and service utilization of these individuals so that they may be matched with the appropriate ICP member organization (if they have not already chosen one).

In addition, DVHA will accept referrals from other sources to be considered for Enhanced Care Coordination, including, but not limited to:

- *Referrals from primary care physicians or other medical providers*
- *Referrals from a Blueprint Community Health Team*
- *Referrals from other LTSS providers*
- *Referrals from the Vermont Chronic Care Initiative (VCCI)*
- *Self-referrals*

33. The adult mental health outpatient population that receives non-categorical case management is a high needs population which should also be addressed by this inter-disciplinary model.

The adult mental health outpatient population that receives non-categorical targeted case management will not automatically be eligible for ECC. However, if they meet the criteria used in the risk stratification process for need of ECC, they will have an ECC Coordinator.

34. If the determination to have services for people with low needs coordinated by the Blueprint or primary care will be based on medical utilization through Medicaid and Medicare, how does that ensure that the coordination needed to keep those costs low is also low? It seems very possible that low use individuals might be receiving a significant level of non-medical supports (through for example the Older American's Act), that is resulting in their low medical utilization. If so, why are the individuals not

being included for Enhanced Care Coordination until those non-Medicaid/Medicare supports fail to be adequate?

The existing programs (such as the Blueprint, Area Agencies on Aging, Vermont Center for Independent Living, and others) are doing an excellent job of supporting individuals with "low needs" (i.e., are not enrollees with high or moderate costs/risk factors). However, any dually eligible individual enrolled in the DE Demonstration may be referred for Enhanced Care Coordination if it is believed that they could benefit from it.

35. What is the role of DVHA's Vermont Chronic Care Initiative (VCCI) in the DE Demonstration?

If an adequate distribution of ICPs is not identified though the ICP RFP process, DVHA may elect to utilize its Vermont Chronic Care Initiative (VCCI) program to provide the enhanced care coordination for enrollees who do not have access to an ICP.

Currently, VCCI does not provide support for dual eligible beneficiaries or for beneficiaries enrolled in the CfC, CRT, DS, or TBI programs. If DVHA utilizes VCCI to provide Enhanced Care Coordination for the DE Demonstration, new VCCI staff will be hired to perform the needed enhanced care coordination function.

36. Would DE Demonstration enrollees who do not have complex needs be auto enrolled into an ICP, but have their care coordination done by Primary Care Physician and CHT?

Yes, all DE Demonstration enrollees will have an ICP member organization on record. If they do not have complex needs as identified through the risk stratification process described above, their single point of contact will be their primary care practice. However, these individuals will have an identified ICP member organization on record which they can access if they develop more complex needs requiring Enhanced Care Coordination.

37. Can enrollees change their ICP member organization?

Enrollees may change their ICP member organization by officially notifying their ICP-Accountable Agent at least 15 days prior to the 1st day of the month in which the change is desired.

38. Will independent program information and option counseling be available to prospective and participating beneficiaries?

The federal government is providing separate funding for Aging Disability Resource Centers (ADRCs) and State Health Insurance and Assistance Programs (SHIPs) to provide this assistance to eligible individuals. In addition, the inclusion of broad stakeholder involvement (including providers, advocates, consumer representative and ombudsmen) throughout the project design should be helpful, since beneficiaries may reach out to these providers and advocacy groups to ask about the project before making a decision about the program and participation.

39. Individuals with cognitive impairments (DD, TBI, dementia, etc.) may need extensive assistance to understand and select their ICP member organization, especially if it is some entity other than the agency currently serving them. Who will provide this type of assistance during enrollment?

Many of these individuals (with cognitive impairments) currently receive services through existing community or long-term care organizations, and this will not change under the DE Demonstration. The State will ensure that all these organizations (including the ADRCs and the SHIPs) understand the DE Demonstration and have the information needed to provide assistance with enrollment and selection of an ICP member organization and a PCP.

40. How will public or private guardians be involved in the enrollment/assessment process?

The State will contact currently existing state-authorized representatives/private guardians and public guardians so they can assist individuals with the enrollment/assessment process. The State will inform state-authorized representatives and guardians about state and ADRC/ SHIP resources so that if they have questions about enrollment/assessment processes they know who to talk to about their questions.

41. We recall that data suggest that 30 - 60 young adults being served by DS who are dually eligible would also be included in the Integrated Family Services initiative based on their age. How will services and funding for these young adults who fall into both of these initiatives be handled? How will services and funding work for any individuals under 18 who are dually eligible and would also be part of the IFS initiative?

The best approach is to serve these individuals (which number very few) through the Integrated Family Services Initiative rather than the DE Demonstration. As such, individuals who are eligible for the Integrated Family Services Initiative will not be eligible for the DE Demonstration.

ICP Payment Mechanisms

42. With regard to the RFP for ICPs, the timeline says: "The State will finalize contracts with these entities and establish provider payment rates." Is this a negotiation following the granting of the RFP or will rates be identified in advance of the RFP?

DVHA will establish the payment mechanisms and rates for Enhanced Care Coordination prior to issuing the RFP for ICPs.

43. How will an ICP be paid for Enhanced Care Coordination? Will rates be based on intensity of needs (i.e., a higher rate for complex cases for care coordination)?

DVHA will pay ICPs (through an ICP Accountable Agent) a set rate per FTE staff needed to provide ECC. The number of FTEs will be based on the needs of individuals served by that ICP (currently estimated as a 1:50 caseload for individuals with very high needs and a 1:150 caseload for others eligible for ECC).

44. [8/5/13] Is there a set rate the Integrated Care Partnership would have to pay to providers of ECC services?

The payment rate for ECC services has not yet been established. It is the intention that the payment from the State to the ICP will be based on the FTEs needed to provide ECC for the enrollees associated with the ICP, and that the amount the ICP would pay to its ECC-providing members would only vary by the number of enrollees served by that member organization.

45. [8/5/13] Payment for ECC should take into account the need for trained backup in case of the chosen ECC's absence.

The State would be interested to know what percentage of FTEs (or other methodology) the existing providers use to calculate the need and costs for back-up care coordinators/case managers in the CfC, CRT, DS and TBI programs.

46. [8/5/13] Does DVHA intend to run/fund all services from DVHA to the Accountable Agent, or just the ECC funding with the bulk of the service funding remaining through the current mechanisms?

In Year One of the DE Demonstration, DVHA will pay the ICP Accountable Agent for ECC services only; reimbursement for all other services will be paid using the current system. When the ICP-Plus model is implemented, the ICP-Plus will be paid for a bundle of services including ECC, but the payment methodology has not yet been determined.

47. Will the current CRT, DS and CfC payment systems stay the same or be altered? Specifically, will DS funding for dual eligible individuals continue to be authorized as specified in our DS System of Care Plan using defined funding priorities, local and State funding committees, and restrictions on use of funding?

In Year One of the DE Demonstration, the current eligibility processes, funding prioritization processes and payment systems for CRT, DS and CfC services will remain; the ECC payment will be separate from and in addition to the current funding.

48. [8/5/13] After Year 1 how will the waivers (CRT, DS, CfC, TBI) be impacted by the bundled payments? Will they be carved out?

The payment mechanisms have not yet been established for the ICP-Plus bundled services payment model.

49. DS providers are encouraged / required to move funding internally from one person to another as needs change. Will this still be possible?

The State wants to continue to encourage flexibility and does not anticipate that the funding flexibility in the DS program will change under the DE Demonstration.

50. If a person on the DS, CRT or CFC waiver chooses not to participate in the Duals, how will payments be handled for their services?

Services for individuals who opt out of the DE Demonstration will continue to be paid the way they are currently paid. There also will be no payment for ECC.

51. [8/5/13] Recent documents indicate that, as of January 1, 2015, the State wants a capitated payment model of care. Our provider network is undercapitalized. To embark upon capitated payment for this high risk and high cost population, especially since it includes CRT and DS populations is very risky. A related concern is the limited availability of data and the infrastructure to do the data analytics required.

Capitated payment for a bundle of services is associated with the ICP-Plus model, which will not be implemented until January, 2016 at the earliest (the second year of the DE Demonstration). At that time, the State and DVHA will issue a Request for Proposals to identify providers that want to engage in this more risk-based model; it will not be mandatory for existing ICPs or any other providers. Among other reasons, the State decided to delay

implementation of the ICP-Plus approach until at least Year Two of the Demonstration to give providers the opportunity to fully understand and implement the State and DVHA's expectations for ECC and the DE Demonstration Model of Care before taking on larger administrative restructuring that would be required to manage bundled payments for service, and to give the State, DVHA and providers the opportunity to develop the data and reporting infrastructure necessary for performance measurement on a smaller scale before moving to performance incentives related to bundling of services.

52. [8/5/13] Will the community-based providers be at fiscal risk for a subset of the dual eligible population, rather than the entire population? If yes, how will risk-based payments be analyzed and calculated on that subset?

Community-based providers will not be at fiscal risk for existing services until the ICP-Plus model is implemented (in January, 2016 at the earliest). The specific methodology for this approach has not yet been developed.

53. [8/5/13] Will the State consider risk corridors for both profit and loss for the ICP-Plus (after the first year)?

The payment parameters for the ICP-Plus approach have not yet been developed. The State is interested in Stakeholders' perspectives regarding profit and loss corridors for ICPs-Plus.

Relationship to Accountable Care Organizations (ACOs), Savings and Performance Incentives

54. What is the expected relationship between the Medicaid and Medicare ACOs and the ICPs? [8/5/13] How will the ICP work in relation to the role of the ACOs?

ACO models provide additional financial incentives for better coordination of care. Currently there are two Medicare ACOs in Vermont; there may be more in the future. The Medicare ACO program is a relationship between the federal Medicare program and the providers that form an ACO. The State is not involved in any of the formal agreements or savings arrangements. These Medicare ACOs continue to be paid for the Medicare services they provide in the same manner as prior to becoming an ACO, but the federal government will share savings with them after the end of each year if the ACO target expenditures are less than what would have been expected.

Under the State Innovation Models grant (SIM), Vermont intends to establish a Medicaid ACO Shared Savings Program (SSP) within the next year. Unlike the Medicare ACO SSP, the design and parameters of the Medicaid ACO program will be established by the State and not the federal government. As the specifics of a Medicaid ACO SSP are developed, the State is committed to making sure that the financial incentives, quality measures, and overall approach are aligned with the goals of the DE Demonstration.

The State, with Stakeholder input, will establish standards regarding the relationship between Medicaid ACO/SSPs and ICPs. ICPs could be stand-alone organizations or could participate as a member of a Medicaid or Medicare ACO provider network. As part of the DE Demonstration negotiations with CMS, the State also will propose that dual eligible beneficiaries be able to be included in the new Medicaid ACO/SSP if their ICP is part of a Medicaid ACO provider network. This type of formal relationship could enhance the success of both an ICP and the ACO, and could be directly beneficial to the care received by the individuals served.

55. Is the attribution of savings to the Medicare ACOs instead of the Duals Demonstration still under consideration? [8/5/13] How will the savings be attributed to the Duals community providers, Medicaid ACOs, Medicare ACOs, State and CMS?

The State continues to be in conversation about the attribution of dual eligible individuals with existing and proposed Medicare and Medicaid ACOs for the purposes of calculating shared savings under those initiatives. This will be a focus of the new integrated SIM/Duals Governance structure.

Specific to shared savings between the State and CMS in the DE Demonstration, the MOU between CMS and the State will define an agreed-upon savings percentage for each Year of the DE Demonstration. These aggregate savings percentages will be applied equally to the Medicaid and Medicare rates paid to DVHA each year, and thus will be netted from the overall funds available for services.

56. [8/5/13] It is not clear how projected savings will materialize. In order to effectively comment, stakeholders must be able to evaluate the proposal with detailed information, especially with regards to projected savings. We currently understand that the DE Demonstration must achieve a certain level of savings in order to create and fund a "quality Shared Savings Pool". As we read page 5 of the Proposed New Organizational Approach, it remains very unclear how this could work. It would be useful for the state to share its projections for savings. Our understanding of the latest proposal suggests that the savings will be limited by certain factors. For example, in the June 25th draft of the DE Demonstration proposal it states, "A core element of the [project] is the provision of Enhanced Care Coordination (ECC) for enrollees." Although there are approximately 22,000 dual eligibles in Vermont, the proposal suggests that almost 9,000 in "Population 4" will not be receiving ECC beyond PCP and CHT care. Further, 8,100 of the dual eligible population that has been categorized as "Population 1" are already being served in the Choices for Care, Community Rehab and Treatment, Developmental Service, and Traumatic Brain Injury programs with varying degrees of case management. The projected cost savings that will be produced by the enhanced care coordination for these two populations should take into consideration the existing case management services and the number of Duals that will not be receiving enhanced care coordination.

The State will not sign the contract with CMS to implement the DE Demonstration unless funding (which includes the financial agreement between the State and CMS, CMS funding for administrative and programmatic costs, and the expected programmatic savings) is sufficient to cover the State's administrative and programmatic costs and the CMS required savings percentages. The original proposal submitted by the State to CMS in May 2012 listed programmatic areas where savings could be achieved for five sub-populations within the DE Demonstration (i.e., CfC, DS, CRT, TBI, other "Non-Specialized Program" High User) based on analyses of integrated Medicare and Medicaid claims data.[1] The State continues to conduct data analyses to explore specific targeted areas for better care and potential savings. These include such areas as unnecessary medications and avoidable hospital readmissions for all groups, and the impact of ECC for the other "Non-Specialized Program" High User" group which has an average Medicare pmpm that is four times higher than the waiver populations and does not currently receive comprehensive care management.

[1] http://humanservices.vermont.gov/dual-eligibles-project/proposal-vermonts-demonstration-grant-to-integrate-care-for-dual-eligible-individuals/view, pages 27-31.

In addition, under contract with the State, Wakely Consulting Group (Wakely) conducted an evaluation in winter 2013 of the potential costs (including detailed new administrative and ECC costs) and high level savings (i.e., not specific to sub-populations) associated with the State's participation in the DE Demonstration. The Wakely Report concluded that "even though the total costs for serving the dual eligibles increases under the Demonstration program, our best projection is that the State spend under the Demonstration program will be less" and "savings under the Demonstration are expected to occur at both the cost level and at the funding level." Wakely's analysis included savings from various areas, including inpatient, emergency room and diagnostic testing utilization; nursing home diversion: and ICP care management.

57. *8/5/13* *How will the financing during year 1 impact capacity and rates? Will the required savings be calculated off of anticipated increases in expenditures or will it come off of existing funding for community-based services?*

Rates and capacity for existing community-based services will not be affected by the administrative and ECC costs of the DE Demonstration or by the savings percentages agreed to between CMS and the State. It is expected that these costs will be paid for through two mechanisms: 1) CMS Implementation Funds awarded to the State (specific amounts and uses will not be known until after a MOU is signed between CMS and the State), and 2) savings achieved by improved service coordination, utilization and outcomes due to the provision of ECC.

58. Will the State provide performance incentives and share savings with ICPs and how does this relate to the Medicaid ACO program? 8/5/13 How will the state avoid perverse incentives between inpatient medical and community-based services?

The new integrated SIM/Duals governance and management structure includes a workgroup on quality and performance measures for all health care reform activities, including those under the DE Demonstration and the proposed Medicaid ACO SSP. A goal of this workgroup will be to design quality and performance measures and methodologies that provide financial incentives to support integrated care delivery and that are in alignment across the DE Demonstration and the Medicaid ACO SSP.

The State plans to create a Quality Incentive Pool to be used for the DE Demonstration and other Medicaid Initiatives that include performance payments. The Pool will be funded through various funding sources, which may include the Quality Withhold funds in the DE Demonstration (if DVHA meets the CMS /State withhold metrics), any savings through the DE Demonstration and through the Medicaid Accountable Care Organization (ACO) Shared Savings Program (SSP), and other sources of funding available for this purpose. Each ICP will have the opportunity to receive payments from this Pool if they meet DE Demonstration performance standards and quality measures. In addition, if ICPs participate in the Medicaid ACO SSP, the ICPs will be eligible for some share of the ACO SSP savings if ACO performance standards and quality measures are met.

The Quality Incentive Pool is key to "avoiding perverse incentives between inpatient medical and community-based services." A primary objective in the development of the quality and performance measures is to craft them so they incentivize coordinated care rather than cost-shifting among inpatient, medical and community-based services.

The parameters for performance payments to ICPs (e.g., measures, criteria for receiving payments) will be established prior to issuing the RFP for ICPs, but the specific amounts will

not be established until the amount of funds in the Quality Incentive Pool is known (i.e., after Year 1 of the Demonstration).

ICP performance payments will go from DVHA to the ICP Accountable Agent since this will be the only contractual relationship between DVHA and the ICPs. The ICP Accountable Agent(s) will distribute performance payments to ICP members using a methodology defined by the State and DVHA.

59. How will the State determine the methodology and amount of performance payments for each provider; will this be decided prior to issuing the RFP for ICPs? [8/5/13] How will the performance funds be distributed? What will be the level of this reimbursement?

The specific performance indicators to be measured will be determined over the coming months - some of these will be required by CMS and some will be state-specific. The parameters (e.g., criteria, relative percentages) for distributing performance payments will be established prior to issuing the RFP for ICPs, but the specific amounts will not be established until the amount of savings is known (i.e., after Year 1 of the Demonstration).

60. How will the cost of measuring performance be covered? What will be the performance indicators? What other data will need to be reported?

The State has requested funds from CMS for State staff to operationalize the DE Demonstration performance measurement system. Development of performance measurements for the statewide health care system also is one of the primary activities of the SIM grant. Every effort will be made to limit the burden on providers regarding the collection of new data.

61. [8/5/13] What input will stakeholders have in designing the performance payment methodology?

Stakeholders will be members of the SIM/Duals Quality and Performance Measures Workgroup. In addition, the State will share the draft DE Demonstration performance payment methodology with a broader group of stakeholders for feedback prior to implementation.

62. [8/5/13] We recommend incentive payments for expanded capacity.

ICPs will receive new funds to pay for the expanded capacity needed to provide ECC.

63. An element of the model is to base payments on changes in utilization and quality. How will the impact of people opting out or becoming ineligible be incorporated into assessing utilization and quality for ICP payment decisions?

The exact methodology for determining the provider incentive payments has not been developed. However, these methodologies will control for changes in the number of enrollees in the DE Demonstration.

64. If the source of savings is primarily from reduced utilization of services such as emergency rooms, hospital stays, nursing homes, and pharmacy, how will the payment structure account for areas such as developmental services where utilization in targeted areas is already well below the per capita utilization?

The exact methodology for determining the *provider incentive payments has not been developed.*

Benefits/Services

65. [8/5/13] Will community providers be able to immediately implement services without prior approval from the ECC or ICT?

Yes. The ECC Coordinator and ICT are not intended to be gatekeepers, but rather to ensure that enrollees' needs are met in a respectful, timely, effective and efficient manner.

66. If the consumer is not eligible for the CRT, DS or CFC waiver services, are their duals services limited to care coordination and Medicaid plan or Medicare regularly funded services? If not, how would this expansion of services be funded? [8/5/13] Will Medicare coverage criteria become more flexible?

Covered services at the beginning of the Demonstration generally will be limited to the new ECC services and existing direct services funded through Medicaid and Medicare. However, the State anticipates that coverage policies to extend benefits beyond traditional services will be evaluated and developed throughout the DE Demonstration using several mechanisms. First, Vermont proposes to adopt the existing, public managed care model authorized by the Global Commitment to Health Demonstration for the DE Demonstration. The public managed care model provides the State with additional flexibility to extend coverage for non-traditional services to the extent such services are clinically appropriate, cost effective and the individual elects to receive such services in lieu of regularly funded services. Additionally, the integration of Medicare and Medicaid services and funding may create opportunities for the State to evaluate and modify existing coverage policies, such as providing services available in CRT or DS (e.g., supported employment, respite) to people who are not eligible for CRT or DS. Furthermore, once implemented, one of the main benefits of the ICP-Plus model is that the bundled payment for HCBS services will allow providers to use flexible services (i.e., those that may not traditionally be covered by Medicare or Medicaid) to meet enrollees' needs. Lastly, as the Demonstration progresses and there are savings, the State may elect to use some of these savings to expand benefits beyond those currently funded by Medicare and Medicaid today.

67. [8/5/13] Investing in flexible services at the outset will enhance the performance of DE and create better outcomes from the start.

Service flexibility will be maximized under the ICP-Plus bundled services payment model expected to be implemented in Year 2 of the Demonstration. In Year 1, the focus is on the provision of ECC and bundled service payments will not be available. While investing in flexible services at the outset of the Demonstration would be optimal, it is not apparent that there will be sufficient funds at the beginning of the Demonstration to develop a flexible services fund to be used by ECC Coordinators.

68. Goals of the dual eligible model include improving access to services such as mental health and social services. Resources have been limiting access to mental health outpatient services and developmental services, so how will the payment structure support greater access?

See responses to the above two questions.

69. Utilization management for DAIL has been delegated to 1) Pediatric and Adult High Technology Home Care Program and 2) Children's Personal Care Services Eligibility, which do not reside in DAIL. It seems the UM role is to maintain policies and procedures related to service authorization; establish criteria to authorize or deny

service requests; and to maintain mechanisms to ensure consistent application of authorization criteria. Does this mean that for DS all of these functions will be tied to requirements developed by the Dept. of Health rather than to DS requirements?

The DE Demonstration will not alter these UM processes.

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Role of Enhanced Care Coordination

70. Will a beneficiary have both a case manager and an ECC Coordinator? Conversely, If the case manager and ECC Coordinator are one and the same person, how will the current case management functions be done that are not typical of care coordinators? For instance, some case managers provide transportation, home visits, staff coordination, substituting for when staff are absent, accompanying for physician and medical care visits and home visits. As another example, they may also be responsible for recruitment, hiring, and supervision of staff or oversight of contractors.

An individual's ECC Coordinator will be responsible for working with the individual to conduct/coordinate a person-directed individual assessment, develop a care plan, and be their single point of contact across all their primary, acute, mental health, substance abuse, developmental, and long term care supports and service needs. Currently individuals enrolled in the CfC, CRT, DS and TBI programs have care coordinators/case managers that primarily focus on the person's services/needs that are related to that specific program. It would be logical that when these individuals choose their ICP member organization for ECC across all their needs, they will choose the same organizations that employ their existing care coordinator/case manager. In this case, it would be in the best interest of the DE enrollee that their existing care coordinator/case manager assumes the additional responsibilities of an ECC Coordinator since this is the person that knows the enrollee best.

In the rare circumstance where the enrollee's ICP member organization believes that the existing case manager cannot assume the additional responsibilities of an ECC Coordinator, the ICP member organization may use the ECC funds to hire additional FTEs to perform the ECC functions. However, the ECC Coordinator must be the single point of contact for the enrollee, and perform all the duties required of ECC Coordinators. In addition, the case manager must be an active member of the care team, and there cannot be duplication of services between the case manager and ECC Coordinator.

71. If someone is enrolled in the DS program and has an ECC Coordinator that is not in their DS agency (because of enrollee choice or assignment when no choice has been made), will the beneficiary also have a DS service coordinator/case manager?

Yes, if that is part of their DS care plan. However, it would be expected that the DS service coordinator/case manager would be an active member of the enrollee's care team and work closely with the ECC Coordinator as part of their routine job duties. There also should not be duplication of services between the case manager and ECC Coordinator.

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72. What would be the caseload size for care coordination? In determining what new resources will be needed to meet the enhanced care coordination requirements, did the analysis look at the current roles of the people performing the functions that will be expanded?

The caseload size for Enhanced Care Coordination will vary by population. For individuals enrolled in the CfC, CRT, DS or TBI programs (who already receive case management / care

coordination), the State anticipates that the new responsibilities for ECC will increase the workload of the existing care coordination/care management staff by 10 - 20%. For other enrollees, the caseload size is estimated as 1:50 for individuals with high needs and 1:150 for others eligible for ECC. However, these caseload estimates may change as the State planning progresses.

73. [8/5/13] Where did the data come from to establish caseload estimates? Are the caseload ratios realistic given the complexity of the population - 1:50 and 1:150 are much higher caseloads than any of the DA/SSA's current programs. A number of people with complex needs do not currently meet these waiver eligibility criteria.

Given that individuals already being served in the CfC, CRT and TBI programs receive some form of care coordination/case management, the State estimated that 20% would need to be added to the existing Medicaid care coordination/care management claims expenditures to pay for the new expectations and function of ECC. A 10% increase was used for the DS enrollees since repeated testimony by these providers have indicated that their staff already perform many of the new ECC Coordinator functions.

The 1:50 ECC caseload ratio is for individuals with very high need. This was based on the existing caseload ratio of 1:25 used in the Vermont Chronic Care Initiative (VCCI) for individuals with intensive needs. The VCCI caseload ratio was adjusted to 1:50 due to the fact that VCCI care coordinators only serve individuals for 3 months (and thus at the peak of their needs), whereas the ECC coordinators will be serving individuals for as long as needed (with varying levels of needs).

The 1:150 ECC caseload ratio for the remaining dual eligible enrollees eligible for ECC was based on Blueprint Community Health Team (CHT) caseload ratios (approximately 1:200) and Area Agency on Aging (AAA) experience for providing Older American Act case management (caseload ratios of 1:150).

The State plans to work with provider representatives in the near future to examine the above assumptions.

74. This model appears to be heavily weighted to "administrative" care management. How and where does the integration of service delivery happen with the consumer? Are we asking case managers to do more or adding another layer of coordination on top of them? How do we achieve integration rather than layers of care coordination?

Primary roles of the ECC Coordinators are to integrate and streamline service delivery, and to work directly with the individual to ensure that his/her needs are met in a timely, respectful and efficient manner. Please see "Care Coordination and Clinical Care for Individuals with More Complex Needs" on page 5 of the Model of Care Summary for a full description.

75. Would ICPs have a role in monitoring health, health coaching, health promotion and prevention?

Yes. That is the intent of a single point of contact to coordinate comprehensive and ongoing care across the full range of the client's needs.

76. Is this creating competition for care coordination processes between: CFC, Blueprint, VCCI, SASH, ICP, ACO, Health Homes? Will this create workforce challenges?

Enhanced Care Coordination is not expected to create competition or workforce challenges. It will improve the ability for all service providers to perform their roles more collaboratively and effectively.

77. Doesn't CMS only allow care coordination by one agency?

CMS is concerned about duplication of services. In the proposed model of the DE Demonstration, the ECC Coordinator must be the single point of contact for the enrollee, and perform all the duties required of ECC Coordinators. In the rare circumstance where there is a separate case manager, the case manager must be an active member of the care team, and there cannot be duplication of services between the case manager and ECC Coordinator.

Interdisciplinary Care Team (ICT)

78. Who are members of a beneficiary's ICT?

The ECC Coordinator, the beneficiary and the PCP representative are core members of the ICT. Other participants will be identified by the ECC Coordinator and beneficiary as those having current active involvement with the beneficiary's care and support services. Examples include but are not limited to medical specialists, home care providers, vocational rehabilitation counselors, mental health counselors, housing support specialists, Transition II Consultants, etc.

79. 8/5/13 The idea of having the Interdisciplinary Care Team (ICT) varied by person makes good sense conceptually, but how will this work given the amount of effort required and the resources available? Will PCPs (or their representatives) be willing to participate in these meetings on a quarterly basis?

The purpose of the Interdisciplinary Care Team (ICT) is to ensure that all providers involved with an enrollee have a comprehensive view of the enrollee's health status, services / supports, socio-economic situation, and goals so that interventions on behalf of the enrollee are coordinated so they are efficient and effective. This requires that the ECC keep the enrollee's comprehensive care plan up-to-date, and convene the ICT members (in-person, by email or by phone) on a quarterly basis and more frequently when changes occur. It is expected that the routine quarterly ICT meetings will be brief, and thus not much of a burden for ICT members to attend. The ICT meetings that occur when a change has occurred in the enrollee's health or other life situation are likely to require more time since new interventions will need to be planned, communicated and /or implemented. While this may require more effort on the part of the ICT members, it is best practice in the medical and LTSS fields.

80. Does the ICT have to meet quarterly (page 120 in MOC) or can it meet as agreed to between the team and the consumer based on consumer needs as they evolve?

The ICT must meet quarterly, but can meet more often as needed. The members of the ICT can attend by phone.

81. Requiring weekly clinical meetings for Enhanced Care participants seems unrealistic - the required frequency should be determined by the person and his/her team.

There is no requirement in the DE Demonstration for weekly clinical meetings.

82. Is this system doing away with the current CRT team led by a case manager, which directs vocational, skills supports, psychiatry, crisis management referrals, crisis bed referrals, street outreach interventionist referrals, treatment court referrals, public inebriate program follow-ups, out-patient therapy immediate and long term referrals?

The DE Demonstration model will not eliminate the existing CRT system or the CRT Team approach. The role of the ECC Coordinator and ICT is to use this team approach as a foundation and expand the focus to meet the full array of service needs of the beneficiary.

Coordination between ECC and Primary Care

83. Is it accurate that under this plan the consumer will have two teams: the ICT convened by the ICP Care Coordinator and the CHT from the Blueprint for their primary care? If yes, what is your vision on coordination/integration of care and teams?

For individuals with non-complex needs, their care will be coordinated by their primary care provider (PCP). For individuals who have needs beyond those provided by their PCP, a key goal of the DE Demonstration is to bridge the gap between medical care and community-based / long term care. As such, these individuals will have an ECC Coordinator who will be responsible for working with the individual to assess their needs and provide a single point of contact to coordinate comprehensive and ongoing care across all providers in the health care system, including medical providers; designated agencies and other long term care providers; other social services providers; and peer support organizations. The ECC Coordinator would:

- *Establish and maintain a routine working relationship with the beneficiary's PCP and the beneficiary's Blueprint Community Health Team (CHT) member(s).*
- *Develop an Interdisciplinary Care Team (ICT) for each beneficiary based on needs identified in the Individual Care Plan, and including the beneficiary's PCP (and CHT where applicable). In other words, if the beneficiary is getting services from a Blueprint CHT, the CHT member(s) would be part of the broader ICT.*

84. How do you envision the ICP ECC Coordinators interfacing and reviewing the CHT Health Plan?

The ultimate goal is for assessments, care plans and other relevant documentation regarding the needs and care of beneficiaries to be housed in Covisint DocSite™. DocSite is a web-based central registry used by the Blueprint Advanced Primary Care Practices to provide real-time access to electronic data and information for care planning, decision support and community care team coordination and collaboration.. The Docsite registry will be the tool used to share beneficiaries' assessments and Individual Care Plans among Interdisciplinary Team Members, and update the Plans as needed.

The registry will be made accessible to team members directly tied to their role in the care planning process for individuals. All team members who have access will be responsible for updating the information based on their interactions with the beneficiary. When updates are made to a case file, all other members of the care team are alerted electronically through the Docsite system. As such, the registry will integrate assessments, documentation of case management, care planning, input from the interdisciplinary team, and support for transitions in care settings.

However, the electronic connectivity to enable direct data feeds into Docsite between all providers will likely not be functional by the DE Demonstration implementation start date of January 1, 2015. Therefore, as an interim step where this connectivity is not available, other

options are being developed to transfer assessment, care plan and other relevant information between the ECC Coordinator, CHT and other care team providers.

85. Does the model allow for ICP member organizations to provide on-site primary care for persons with complex needs, or do they have to receive their health care only at Blueprint primary care site?

If available, on-site primary care is an excellent option.

86. Will people be forced to switch doctors if their current primary care practice (PCP) is not part of the Blueprint Advanced Primary Care Practice (APCP)? Will this affect their specialty medical care due to Physician-Hospital Networks or affiliations?

Dual Eligible Demonstration enrollees will not have to change their primary care physician (PCP) if their PCP is not participating in the Blueprint Advanced Primary Care Practice (APCP). However, the intent is that the majority of individuals' PCP will be participating in the Blueprint by the DE Demonstration start date of January 1, 2015 since more PCP practices are becoming part of the Blueprint APCP program.

Assessment Tools and Processes

87. I am a bit confused about the name of the assessment tool. Is it "DE Demonstration Assessment" or "Health Risk Assessment"? Or are they two different things?

The DE Demonstration assessment/health risk assessment is intended to be the same initial intake assessment. This initial intake assessment leads to other assessments only as needed.

88. Will the State require that a specific assessment tool be used, and will it vary by population?

The current plan is the State will allow the CRT, CFC, DS, TBI and SASH programs to continue to use their existing assessment tools. However additional questions may be required to be added to some or all of these tools to ensure that they cover the range of needs included in the goals of the Demonstration. For the DE enrollees not served in these existing programs, the State is still exploring the specific assessment tool that will be used.

89. What is the process for updating the assessment when a significant change occurs in the beneficiary's medical or life situation? For example, can the current mental health assessment tools developed by DMH be utilized for this assessment update or will these newly developed assessment tools be used to address all aspects of care?

In this situation, the ECC Coordinator must identify which aspects of the assessment are affected by the significant change, and re-evaluate those components and update the information accordingly.

90. The MOC states that the goal is to conduct initial health risk assessments within 90 days of enrollment. However, recognizing that this may not be feasible depending on the number of beneficiaries enrolled at each ICP member organization, the State will use claims data to assist in helping these organizations to determine the prioritization for conducting the assessments. How will the plan address those individuals who refuse to have a health risk assessment?

Individuals have the right to refuse to participate in a health risk assessment. The State will examine current practice in the CRT, CFC, DS and TBI programs regarding when an individual refuses to have a health risk assessment, and will adopt a similar approach for the DE Demonstration.

Care Planning

91. Will the Developmental Services (required) Individual Support Agreement become part of the comprehensive Person-Directed Care Plan, or an attachment, or will it be replaced by the CPDCP?

The Individual Support Agreement would be part of the comprehensive care plan, at a minimum as an attachment.

92. I'm concerned that the use of a medical model data system (i.e. Docsite) will force us into a medical model of service. Developmental services do not "treat" a developmental disability, they instead provide supports. "Treatment teams" and "treatment plans" are intentionally not part of our lexicon. I know it seems like semantics, but language is important.

This is a very important point and it is not just semantics. Docsite is a tool for sharing information and does not dictate the content of the information. A major goal of the DE Demonstration is the sharing of information between long term care service and support providers and primary care providers. Sharing information back and forth between DS and primary care providers should only improve an individual's comprehensively managed plan of care which acknowledges that individuals have both medical and LTSS needs.

Consumer Direction and Choice

93. Do consumers have the choice of staying enrolled in Duals or moving into the CFC, CRT or DS waivers?

These are not competing choices. Regardless of whether a consumer chooses to participate in the DE Demonstration, they can still be in the CFC, CRT or DS Waiver program.

94. What is the real, working distinction between case management and person centered/person-directed care within the context of the DE project? "Person-centered" could logically entail benevolent case management (as opposed to "person-directed"). Does the current direction of the DE project allow for emphasis upon beneficiary control (e.g. encompassing clear and reasonable choice at many steps/levels along the way)?

The foundation of the DE Demonstration is creating an integrated person-directed support system, defined by Vermont's Dual Eligible Person Centered Workgroup as follows:

> *A person-directed support system is life-affirming, strength-based, satisfying, humane, and meaningful. Core values include choice, dignity, respect, self-determination, and purposeful living.*

To operationalize this person-centered foundation, the following standards will guide all activities by the ECC Coordinator and ICT members:

- *Consistently educate, empower and facilitate the beneficiary to exercise his or her rights and responsibilities.*
- *Mutual respect for the expertise of all members of the beneficiary's team, especially the beneficiary.*
- *Involve the beneficiary as an active team member and stress beneficiary-centered collaborative goal setting.*
- *Provide information and support to the beneficiary in making choices, as needed.*
- *Always develop, monitor and review the beneficiary's care plan with the beneficiary.*
- *Ensure beneficiary's goals and preferences are identified, documented in the care plan and addressed.*
- *Ensure all verbal and written communication with the beneficiary is presented in a manner that the beneficiary can understand. Always ask questions of the beneficiary to ensure that the/she understands it.*
- *Provide education to the beneficiaries and families regarding health and social needs.*
- *Identify the beneficiary's informal support systems/networks in relationship to his or her functional and safety needs.*
- *Report information to team, beneficiary and other appropriate heath care providers as needed.*
- *Assess and assist the beneficiary in identifying and addressing quality of life issues.*
- *As appropriate and with the beneficiary's permission, represent the beneficiary's point of view when the member is unable to participate in decisions.*

Also, please see the following section on Consumer Self-Management.

Consumer Self-Management

95. [8/5/13] Support for enrollee to self-manage some or all services. How will this work / be paid?

DE Demonstration enrollees who want to self-manage some or all of their services will have the option to use either the CfC Flexible Choices Program or the DS Self-Management Program. The State is not currently planning to make changes to the policies and procedures for the CfC Flexible Choices Program or the DS Self-Management Program for individuals enrolled in the DE Demonstration; however, over time the State may look at the rules, policies and procedures to determine if best practices could be used from both sets of programs. DE Demonstration enrollees not served by one of these two programs (i.e., CfC and DS) would choose one of these two models for self-management.

In the DS Self-Management Program, individuals who self-manage some of their services have an affiliation with a DS Designated Agency. However, individuals who manage <u>all</u> of their services use the Supportive Intermediary Service Organization (ISO), Transition II, and only return to the Designated Agency if they no longer want to manage all services. In both situations, the DS enrollee (or their designee) submits timesheets/bills directly to ARIS for their self-managed services.

CfC Flexible Choices enrollees who self-manage do not have a formal affiliation with a CfC care management provider but do have a "Consultant" who is employed by Transition II. The individual submits timesheets/bills to ARIS directly.

96. If individuals are managing their own services, will they be required to have an ECC?

All enrollees, including those who self-manage, will be required to have a PCP and an ICP member organization on record in case they need to access ECC at any point in time. However, no enrollee is required to access ECC. If the enrollee's needs are completely addressed by the services that they self-manage, they may not want or need to access ECC services. However, if they have service or support needs that go beyond those that they self-manage, they could access their chosen/assigned ECC provider if warranted.

97. [8/5/13] What is the relationship between self-directing and the ICP Accountable Agent? The role of the Accountable Agent is described in part as "Provision of all ECC functions. How can this be in a participant directed/managed arrangement - which is also described "as the foundation"?

*A primary role of the ICP Accountable Agent is to **assure** provision of ECC by an ICP member organization when needed by an enrollee (see above responses for more detail).*

98. Will there be an Interdisciplinary Care Team (ICT) for a person who self-manages? If so, which provider/organization would be responsible?

If the enrollee self-manages all of their services and supports, they will not receive ECC and will not have an ICT. The enrollee will only have an Interdisciplinary Care Team (ICT) if they are receiving ECC. The ICT will be comprised of members deemed necessary by the enrollee and their ECC Coordinator. The ICP member organization providing the enrollee's ECC will be responsible for assuring the provision of the ICT. If applicable, the enrollee's CfC "Consultant" would most likely be part of the individual's ICT.

99. Must ICPs have a relationship with ARIS for consumers who want to self-manage?

The State will maintain its contract with ARIS to support individuals who choose to self-manage their services. As such, the enrollee's ICP member organization does not need to have a formal relationship with ARIS; however, Enhanced Care Coordinators will need to understand the role of ARIS for supporting these individuals.

100. In DS a large percentage of people/families manage a portion of their services but not all of them. Will this be allowable in the duals project?

Yes.

101. The discussion (in the Model of Care) on consumer self-management references only CHT and VCCI as providing these supports? Where do peer supports and recovery coaches from behavioral health providers come in?

Peer supports and recovery coaches should be included in the description of consumer self-management. They also could be members of an enrollee's ICT.

State and ICP Infrastructure Support

102. [8/5/13] The proposal overlooks potential issues with data administration and sharing. Many LTCSS operations lack EHRs which will limit their access to the data needed for coordination of all Medical, HCBS and LTSS needs (page 3 of proposed new organizational approach). ICP providers will need to make capital improvements in

order to achieve the level of coordination expected. These improvements will require financial resources the providers don't have in most cases.

The State recognizes that many LTSS providers do not have robust data management and reporting infrastructures and considers these providers as "full-spectrum" providers whom must be brought into the State's Health Information Exchange (HIE). This is a priority of Vermont's SIM grant, as highlighted in Vermont's Health Care Innovation Plan submitted as part of the SIM grant proposal in 2012:

- *"HIT Strategy 1: Connect everybody. Create a statewide distributed network of health information that reflects clinical and other life data collected from and shared, with appropriate consent, with the full spectrum of health care providers (not just doctors and hospitals), social service organizations, families, and individuals." (Page 90)*
- *"EHR and clinical data systems not supported by the SMHP's EHR Incentive Program payments will be complemented by investments through SIM in expansion of clinical data systems for mental health and substance abuse services providers and long term support and services providers in institutional and community settings." (Page 95)*

The DE Demonstration Funding Application to CMS supports the above efforts by including $1.5 million for Infrastructure Grants to help ICPs with capacity building and administrative infrastructure start-up enhancements (e.g., billing, IT, and reporting systems, laptops for the ILA and other assessment tools). The Funding Application to CMS also includes funds to support the transfer of data between the various assessment instruments and the ECC clinical registry, to adapt IT systems to support this connectivity, and to help these ICPs obtain connectivity to the State's Health Information Exchange (HIE). In addition, the delayed implementation of the ICP-Plus approach is intended to give the State, DVHA and providers the opportunity to develop the data and reporting infrastructure necessary for performance measurement on a smaller scale before moving to performance incentives related to bundling of services.

The State also has other mechanisms for supporting provider connectivity to the HIE, including resources identified through the State's Health Information Technology (HIT) Plan.

103. With regard to the Program Infrastructure grants, has there been an evaluation of current IT interface capability with the prospective providers?

Yes. The State's HIT team already has conducted high level initial assessments of the DAs, Home Health Agencies and the nursing home/residential care homes/assisted living facilities regarding their HIT status and gaps for HIE engagement.

104. [8/5/13] How much of the State Innovation Models (SIM) grant from CMS is available to support the administrative tasks / requirements of the DE Demonstration and specific providers, and for what purposes (e.g., HIE/doc site, organizational development, triage protocols with Blueprint, PCPs, etc.)?

The SIM grant funding will support efforts for the State of Vermont to strengthen its infrastructure and capacity to implement and evaluate statewide health care payment and delivery system reforms. The State also has submitted a DE Demonstration funding proposal to CMS for two years (the maximum time period allowed). Funding for the two projects (SIM and DE Demonstration) will be administered through the new integrated SIM/Duals governance and management structure.

105. I'm unclear about how the assessment/Docsite issues will be resolved when neither the DS agencies nor the DS part of the DAIL Division currently have these in place.

Some of the DS agencies have EHR's, but they have different types that are not compatible. How will this be paid for and who will provide the technical support to the users at the State and local level?

The DE Demonstration Funding Application to CMS includes funds to support the transfer of data between the various assessments and Docsite, to adapt IT systems to support connectivity, and to provide technical assistance to assessment users at the state and local level. These issues also will be addressed by the SIM/Duals Health Information Exchange Workgroup.

106. [8/5/13] How will the $1.5 million for ICP start-up costs be distributed - will it be determined by the number of covered lives?

ICPs will request funding from the Infrastructure Grants in their response to the ICP RFP, and must identify the specific uses and costs of the requested funds. The State will distribute funds based on this information.

107. Will the State/DVHA be able to supply analytics regarding performance measures to providers on a real-time basis?

No, real-time data (live data feeds) from the State and DVHA to ICPs will not be available regarding performance measures.

108. [8/5/13] How will health care utilization be managed without real time data?

The purpose of managing health care utilization is to maintain the quality and efficiency of health care delivery. This can be accomplished by caring for individuals at the appropriate level of care; by coordinating their health care benefits; and by identifying, monitoring, evaluating, and resolving issues that may result in inefficient delivery of care or that may have an impact on resources, services, and patient outcomes. While real-time data is extremely valuable in these endeavors, it is not often available for two primary reasons: 1) health information exchanges (HIEs) are not fully established to enable this real-time data transfer to occur; and 2) most providers, insurance carriers and other care management entities do not have established interfaces between their clinical management tools (e.g., EHRs, clinical registries) and the HIEs. Instead, most entities manage health care utilization through proactive data analysis, utilization review, case management, and referral management.

The State and its IT partners are aggressively working towards the establishment of a statewide HIE and connectivity for all health care and LTSS providers; however, it is unlikely that this will be available at the beginning of the DE Demonstration. Until these real-time data are available, DVHA will provide health care service utilization data reports to ICPs for their enrollees to assist the Enrollees' Enhanced Care Coordinators to support them in receiving quality and efficient care.

109. [8/5/13] What will be the lag time on the utilization data (related to performance measures and care coordination)?

The specific approaches for reporting on performance metrics and other data will be finalized through the SIM/Duals Quality and Performance Measure Workgroup, which will include members from the provider community knowledgeable about the DE Demonstration ICP model. However, the State wants to support providers by supplying the data they need in the frequency needed for them to be successful in improving care delivery and cost. Factors that will contribute to the frequency of data reports include the measure and data source (e.g., claims data- which contains a time lag, enrollment data, and annual survey data) and the

uses of the data (e.g., programmatic performance, administrative purposes, and care management).

110. Will the State provide the following data reports for providers?
- **Monthly enrollment by ICPs and member organizations**
- **Monthly need stratification of enrollees by ICP (to assist with ECC assignment/caseloads)**
- **Monthly data on performance metrics by ICP**
- **Analyses based on ad hoc requests from ICP Accountable Agents**

The State intends to provide monthly reports to ICPs on enrollment; the frequency of other data reports will be determined according to their purpose and availability of reliable data. The State does intend to be able to conduct analyses based on ad hoc requests from ICP Accountable Agents.

Policies, Procedures and Documentation

111. There is mention of "DE Demo Policies and Procedures." What will/do these include and how will they interface with current requirements? Will the policies, procedures, practices and requirements currently in place for Developmental Services, CRT, CfC and TBI providers remain or be superseded by Duals in whole or in part? For instance, will DS agencies continue to adhere to the existing Health and Wellness Guidelines or will these be replaced by new guidelines?

The specific DE Demonstration policies and procedures have not yet been developed. However, they are intended to complement and not replace existing program policies and procedures. As such, the current plan is that all policies, procedures, practices and requirements currently in place for these programs will remain.

112. 8/5/13 The roles of these entities and non-DVHA departments are murky in this description. Will there be two systems (duals and non-duals) that operate very differently?

The State intends to develop the DE Demonstration system of care to be compatible with the system of care for non-duals.

113. 8/5/13 With the long term care component it appears that a very complicated funding process could be replaced. How does the Duals initiative interface with emerging efforts on DS by the Legislature (e.g. the work group) and DAIL (the Task Force) which is intended to develop goals and strategies for the future?

The triennial review of the DS System of Care plan will be underway this fall and will be informed by the recommendations of the current Legislative DS work group and DAIL's year-long task force. The DS Task Force will consider and develop a strategic plan to support the needs of individuals with developmental disabilities, their families, and their communities through sustainable models of delivery and payment, aligned with anticipated changes to health and payment reform over the next two (2) decades. Since the new ICP-Plus model and the specific methodology for this approach has not yet been developed, the State and DVHA will have the benefit of considering the work of the DS Task Force when it issues a Request for Proposals to identify providers that want to engage in the DE Demonstration project.

114. [8/5/13] Will DAIL have a role with people who are dually eligible? If so, what might that be, given the roles that are being suggested for the Accountable Agent?

DAIL anticipates having a continued leadership role carrying out its mission to serve people with developmental disabilities and their families through implementation of its Legislative mandate embodied in the Developmental Disabilities Act of 1996. Specifically, it guides eligibility, resource allocation, and supports the values and principles of our work through quality management, technical assistance, and administrative oversight with respect to DS services. The Principles of Service embodied in the Act complement the core elements of the DE Demonstration.

115. What impact will there be on existing DS Quality Review processes? Will there be an additional DEP Quality Review Process?

At this point, the DS Quality Review process will remain the same. The DE Demonstration is developing quality standards and measures to review (likely both process and outcome measures). CMS has quality standards and reporting requirements but the specific standards and reporting requirements for the 3-way agreement between CMS, AHS and DVHA have not yet been developed.

116. Will current documentation requirements continue or be superseded by Duals?

Current documentation requirements will continue. Additional documentation requirements will likely be necessary, however they have not been developed yet and the State would want to only require new requirements as necessary to carry out new functions.

117. [8/5/13] Paperwork should not be duplicative and should involve input from Stakeholders.

The State will make every effort to ensure that any new documentation requirements for the DE Demonstration are not duplicative of existing requirements and will seek input from Stakeholders where applicable (e.g., requirements that are not dictated by CMS).

Training

118. The proposal identifies the Blueprint as meeting with ICP member organizations to determine training elements for evidence based practices to be used in behavioral health. What is your vision on how and when this would happen?

This has not been fully developed; however, it will likely be part of the Model of Care Training curriculum.

119. Could there be a role for the Association (Vermont Council of Developmental and Mental Health Services) in preparing and delivering the training for ICP member organizations?

Yes.